Diabetes and Endocrinolo
1919 Lincoln Way, Suite 211
Coeur d' Alene, ID 83814

NEW DIABETES EDUCATION PATIENT INFORMATION

Patient Name:_____ ***Date of Birth:*** _____

*Age @ Diagnosis:*_____ *New diagnosis: Y / N* *Type 1 / Type 2 / Don't know or not sure*

Blood Glucose testing and Diabetes questionnaire

Are you currently testing your blood glucose? ❑ Yes ❑ No	If Yes, how often and what time of day do you test?	What type of glucometer do you use?

	Yes	No
Do you have hypoglycemia episodes that you can't feel?		
Do you carry food to treat hypoglycemia episodes?		
Do you wear a medical ID?		
Have you required assistance from others to treat your lows?		
Do you have a glucagon emergency kit?		
Do you always check your blood sugar before you drive?		
Have you ever had a low blood sugar while driving?		
Do you have a sick day plan and/or disaster plan for your diabetes supplies?		
Do you have ketone test strips at home?		
Have you had any hyperglycemic (high blood sugars) episodes in the past 2-3 weeks?		
Have you had any hospital/ER visits in the past 3 months for high or low blood sugars?		
What was your last A1C?		

Social/Lifestyle/Quality of Life

Are you pregnant or plan to become pregnant? ☐ **Yes** ☐ **No** Do you smoke? ☐ Yes ☐ No

***Employment* factors you have that might impact your diabetes self-care (Check all that apply)**

- ❑ Variable/Rotating Shifts
- ❑ Unpredictable Meal Breaks/ physical activity
- ❑ Unsupportive supervisor
- ❑ Sedentary job
- ❑ Nowhere to keep diabetes testing/medication supplies
- ❑ Other: _____

Can you describe what diabetes is:
☐ No ☐ Yes, explain:

Other factors that might impact your diabetes self-care

- ❑ None
- ❑ Relationship conflicts or lack of support
- ❑ Hectic schedule
- ❑ Cultural/Religion practice
- ❑ Lack of Motivation
- ❑ Other health issues
- ❑ Financial Concerns
- ❑ Depression/Anxiety
- ❑ Stress
- ❑ Diabetes Burnout
- ❑ Diabetes Regimen too complicated
- ❑ Confusion about my diabetes regimen
- ❑ Lack of knowledge
- ❑ Other:_____
- ❑

Patient Identification - Write in or attach patient label
Name:
MRN #:
CSN #:
DOB/Sex:

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Have you had instructions on managing your diabetes or diabetes education in the past?

- ❑ No
- ❑ Yes/Location

_____

Any hearing, eyesight, reading issues or language barriers that impact your learning

☐ Yes ☐ No

Please explain:_____

How confident are you in managing your diabetes on a scale from 1 (not confident) to 10 (totally confident)?___

Why:_____

How do you like to learn new things? (check all that apply)

- ❑ Reading
- ❑ Lectures/Classes
- ❑ Using the Internet
- ❑ Watching Videos/ TV
- ❑ Individual / demonstrations

Nutrition, Activity, and Medical History

Current Height: _____ Current Weight: _____ Weight changes in the past year? _____

What food planning methods have you followed in the past? (check all that apply)

- ❑ Calorie counting
- ❑ Carbohydrate Counting
- ❑ Low Fat
- ❑ Exchange Lists
- ❑ No added sugar
- ❑ Low Carb
- ❑ South Beach
- ❑ Low Sodium
- ❑ Weight Watchers
- ❑ Paleo
- ❑ Other:_____
- ❑ Food Allergy/Cultural restriction

What method of food planning are you using now?

How many times per week do you eat out? (including beverages)

☐ **0** ☐ **1-2** ☐ **3-4** ☐ **>4**

Do you cook your own meals? ☐ Yes ☐ No

Please explain:_____

What times of day do you typically eat? Breakfast: _____ **Lunch:** _____ **Dinner:** _____

What kind of foods do you typically choose as snack foods?

How often do you drink juice?

- ❑ One or more a day
- ❑ Few times a week
- ❑ Less than once a week
- ❑ Never

How often do you drink Regular Soda?

- ❑ One or more a day
- ❑ Few times a week
- ❑ Less than once a week
- ❑ Never

How often do you drink Alcohol?

- ❑ One or more a day
- ❑ Few times a week
- ❑ Less than once a week
- ❑ Never

Do you have any other relevant medical conditions or diabetic complication? ❑ Yes ❑ No

Please list: _____

_____

Do you get deliberate and regular exercise? ❑ Yes ❑ No

How often and what type? _____

Do you take any diabetes medications? ❑ Yes ❑ No		**Please list name(s) and dose(s):** _____ _____
Do you have any concerns about your Diabetes medications? ☐Yes ☐No		**If Yes please explain:**
What is your preferred Pharmacy?		**<u>What would you like to learn about today or what changes would you like to make?</u>**
Location and date of last eye exam:		
Are you legally blind or have cataracts: ☐ Yes: _____ ☐ No		**<u>What concerns you most about having Diabetes:</u>**
Date of last dental exam:		
Date of last foot exam:		